IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF SOUTH DAKOTA

TERRI BRUCE, *Plaintiff,* v. STATE OF SOUTH DAKOTA and LAURIE GILL, in her official capacity as Commissioner of the South Dakota Bureau of Human Resources *Defendants.*	)	Case No. 17-5080

EXPERT DISCLOSURE REPORT OF GEORGE RICHARD BROWN, MD, DFAPA

I, George R. Brown, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

1. The purpose of this declaration is to offer my expert opinion on: (1) the medical condition known as gender dysphoria; (2) the prevailing treatment protocols for gender dysphoria; and (3) whether there is a legitimate medical basis for exclusion (ww) in the South Dakota State Employee Health Plan for Fiscal Year 2015 ("SDSEHP" or the "Plan") at page 56, which categorically excludes coverage for "[s]ervices or drugs related to gender transformations."

2. In preparing this report, I reviewed a copy of the Plaintiff's Complaint, Defendants' Answer, and the SDSEHP, which is attached as Exhibit B.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation.

PROFESSIONAL BACKGROUND

4. I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman; contributing to the administrative, teaching, and research missions of the Department of Psychiatry; consulting on clinical cases at the University and at Mountain Home Veterans Health Administration ("VHA") Medical Center, where I also hold an appointment; and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves researching, teaching, and consulting about health care in the military and civilian transgender populations.

5. I also hold a teaching appointment related to my expertise with health care for transgender individuals and research at the University of North Texas Health Services Center ("UNTHSC"). My responsibilities include teaching and consultation with UNTHSC and the Federal Bureau of Prisons staff regarding health issues for transgender individuals.

6. In 1979, I graduated *Summa Cum Laude* with a double major in biology and geology from the University of Rochester in Rochester, New York. I earned my Doctor of Medicine degree with Honors from the University of Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at the United States Air Force Medical Center at Wright-Patterson Air Force Base in Ohio. From 1984-1987, I worked in and completed the United States Air Force Integrated Residency Program in Psychiatry at Wright State University and Wright-Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

7. I first began seeing patients in 1983. I have been a practicing psychiatrist since 1987, when I completed my residency. From 1987-1991, I served as one of the few U.S. Air

Force teaching psychiatrists. For the last 25 years, I have worked with both the Department of Veterans Affairs and East Tennessee State University, Department of Psychiatry.

8. Over the last 35 years, I have evaluated, treated, and/or conducted research personally with 600-1,000 individuals with gender dysphoria and other issues related to gender identity and during the course of research-related chart reviews with over 5,100 patients with gender dysphoria.

9. For three decades, my research and clinical practice has included extensive study of health care for transgender individuals. *See* Brown Ex. A (CV). I have authored or coauthored 43 papers in peer-reviewed journals and 21 book chapters on topics related to gender dysphoria and health care for transgender individuals, including the chapter concerning gender dysphoria in Treatments of Psychiatric Disorders (3d ed. 2001), a definitive medical text published by the American Psychiatric Association, and in all versions of the Merck Manual of Medical Therapeutics from 1997 to date. The Merck Manual is the longest continuously published medical text in the United States and is translated into dozens of languages. The 20th Edition is currently in press.

10. I have served for more than 15 years on the Board of Directors of the World Professional Association for Transgender Health ("WPATH"), the leading international organization focused on health care for transgender individuals. WPATH has over 2,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of gender dysphoria.

11. I was a member of the WPATH committee that authored and published in 2011 the current version of the WPATH Standards of Care (Version 7) (the "WPATH standards").

The WPATH standards are the operative collection of evidence-based treatment protocols for addressing the health care needs of transgender individuals. I also serve on the WPATH committee that will author and publish the next edition of the Standards of Care (Version 8), as a Co-Chair of a committee and an author.

12. Without interruption, I have been an active member of WPATH since 1987. Over the past three decades, I have frequently presented original research work on topics relating to gender dysphoria and the clinical treatment of transgender people at the national and international levels, including at 1/3 of all medical schools in the United States and in 7 countries.

13. I have testified or otherwise served as an expert on the health issues of transgender individuals in numerous cases heard by several federal district and tax courts. A true and correct list of federal court cases in which I have served as an expert is contained in the "Forensic Psychiatry Activities" section of my Curriculum Vitae, which is attached hereto as Exhibit A.

14. In preparing this report, I relied on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields and my 35 years of clinical experience in evaluating, treating, and conducting research with patients with gender dysphoria and other issues related to gender identity. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

15. I am being compensated at an hourly rate for actual time devoted, at the rate of $400 per hour for any clinical services, review of records, or preparation of reports or declarations; $500 per hour for deposition testimony; $600 per hour for in-person court testimony or by half day increments, whichever is less; $2000 per half day for travel time (or otherwise); $4,000 per full day spent out of the office for deposition testimony; and $4,800 per full day spent out of the office for trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

GENDER DYSPHORIA

16. The term "transgender" is used to describe someone who experiences any significant degree of misalignment between their gender identity and their assigned sex at birth.

17. Gender identity describes a person's internalized, inherent sense of who they are as a particular gender (e.g, male or female). For most people, their gender identity is consistent with their assigned birth sex. Most individuals assigned female at birth grow up, develop, and manifest a gender identity typically associated with girls and women. Most individuals assigned male at birth grow up, develop, and manifest a gender identity typically associated with boys and men. For transgender people, that is not the case. Transgender women are individuals assigned male at birth who have a persistent female identity. Transgender men are individuals assigned female at birth who have a persistent male identity.

18. Although the precise etiology of gender identity is unknown, research indicates that gender identity has a biological component, meaning that each person's gender identity (transgender and non-transgender individuals alike) is, in part, influenced by biological factors, and not just social, cultural, and behavioral ones.

19. Regardless of the precise origins of a person's gender identity, there is a medical consensus that gender identity is deep-seated, set early in life, and impervious to external influences.

20. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5") is the current, authoritative handbook on the diagnosis of mental disorders. Mental health professionals in the United States, Canada, and other countries throughout the world rely upon the DSM-5. The content of the DSM-5 reflects a science-based, peer-reviewed process by experts in the field.

21. Being transgender is not a mental disorder. *See* DSM-5. Men and women who are transgender have no impairment in judgment, stability, reliability, or general social or vocational capabilities solely because of their transgender status.

22. Gender dysphoria (GD) is the diagnostic term in the DSM-5 for the condition that can manifest when a person suffers from clinically significant distress or impairment associated with an incongruence or mismatch between a person's gender identity and assigned sex at birth.

23. The diagnosis of GD in the DSM-5 (pps. 451-459) involves two major diagnostic criteria for adolescents and adults, synopsized below:

a. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:

   i. A marked incongruence between one's experience/expressed gender and primary and/or secondary sex characteristics.

   ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experience/expressed gender.

iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.

iv. A strong desire to be of the other gender.

v. A strong desire to be treated as the other gender.

vi. A strong conviction that one has the typical feelings and reactions of the other gender.

b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

24. The clinically significant emotional distress experienced as a result of the incongruence of one's gender with their assigned sex and the physiological developments associated with that sex is the hallmark symptom associated with gender dysphoria.

25. Only a subset of transgender people have the clinically significant distress or impairment that qualifies for a diagnosis of gender dysphoria.

26. Individuals with gender dysphoria may live for a significant period of their lives in denial of these symptoms. Some transgender people may not initially have the language for their distress or the resources to find support until well into adulthood.

27. Particularly as societal acceptance towards transgender individuals grows and there are more examples of successful transgender individuals represented in media and public life, younger people in increasing numbers have access to medical and mental health resources that help them understand their experience and allow them to obtain medical support at an earlier age and resolve the clinical distress associated with gender dysphoria.

TREATMENTS FOR GENDER DYSPHORIA

28. Gender dysphoria has well-established community standards for treatment, which are highly effective as applied in an individualized treatment plan for patients with this diagnosis.

29. The American Medical Association ("AMA"), the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective. See American Medical Association (2008), Resolution 122 (A-08) (attached as Exhibit C); American Psychiatric Association, Position Statement on Access to Care for Transgender and Gender Variant Individuals (2012) (attached as Exhibit D); Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (2017) (attached as Exhibit E); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2008) (attached as Exhibit F).[1]

30. The protocol for treatment of gender dysphoria is set forth in the WPATH standards and in the Endocrine Society Guidelines. First developed in 1979 and currently in their seventh version, the WPATH standards set forth the authoritative protocol for the evaluation and treatment of gender dysphoria. This approach is followed by clinicians caring for individuals with gender dysphoria. As stated above, I was a member of the WPATH committee that authored

[1] Additional organizations that have made similar statements include: the American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American College of Nurse Midwives, American College of Obstetrics and Gynecology, American College of Physicians, American Medical Student Association, American Nurses Association, American Public Health Association, National Association of Social Workers, and National Commission on Correctional Health Care.

the SoC (Version 7), published in 2011. A true and correct copy of that document is attached hereto as Exhibit G.

31. Depending on the needs of the individual, a treatment plan for persons diagnosed with gender dysphoria may involve components that are psychotherapeutic (i.e., counseling as well as social role transition – living in accordance with one's gender in name, dress, pronoun use); pharmacological (i.e., cross-sex hormone therapy); and surgical (i.e., gender confirmation surgeries, like hysterectomy for those transitioning to the male gender and orchiectomy for those transitioning to the female gender). Under each patient's treatment plan, the goal is to enable the individual to live all aspects of one's life consistent with his or her gender identity, thereby eliminating the distress associated with the incongruence. Gender dysphoria is therefore a curable medical condition when treated appropriately.

32. Individual patients' treatment needs vary. For example, some patients need hormone therapy and surgical intervention, while others need just one or neither. Generally, medical intervention is aimed at bringing a person's body into some degree of conformity with their gender identity.

33. Many of the same types of surgical care prescribed for gender dysphoria—including mastectomies, hysterectomies, and genital reconstruction—are routinely performed as medically necessary care for other medical conditions.

34. Under the WPATH standards, genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for referral for a specific surgical treatment.

35. Under the WPATH standards, one referral from a qualified mental health professional is needed for breast/chest surgery. The patient must also meet the following criteria

a. Persistent, well-documented gender dysphoria.

b. Capacity to make a fully informed decision and to consent for treatment.

c. Age of majority in a given country (if younger, follow the SOC for children and adolescents).

d. If significant medical or mental health concerns are present, they must be reasonably well controlled.

SDSEHP'S CATEGORICAL EXCLUSION OF COVERAGE FOR "SERVICES OR DRUGS RELATED TO GENDER TRANSFORMATIONS"

36. There is no legitimate medical basis for SDSEHP's exclusion (ww), which categorically excludes coverage for "[s]ervices or drugs related to gender transformations."

37. Contrary to Defendants' Answer at ¶¶ 9, 22, there is no "existing dispute in the medical field" regarding "whether there is a legitimate medical justification" for such exclusions. That statement may have been true 30 years ago, but it is clearly out of step with recent decades of work in this field.

38. As discussed above, every major medical organization in the United States, including the AMA, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association agrees that transition related care, including cross-sex hormone therapy and surgery, is medically necessary and effective treatment for individuals with gender dysphoria.

39. The SDSEHP at page 11 defines "Medically Necessary" as "Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine." There is no dispute in the mainstream

medical community that transition-related care, including cross-sex hormone therapy and gender confirmation surgery, treats an "illness" or "condition," and that such care "meet[s] accepted standards of medicine."

40. As recently summarized by WPATH's "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A." (attached as Exhibit H), decades of studies and research have demonstrated that transition-related care, including cross-sex hormone therapy and surgery, is safe and effective. Based on this robust body of research, an independent medical board in the U.S. Department of Health & Human Services issued a decision in 2014, rescinding a Medicare policy that had excluded surgery from Medicare coverage (attached as Exhibit I). The decision explained that the Medicare surgery exclusion for patients with a diagnosis now known as gender dysphoria was based on a medical review conducted in 1981 and failed to take into account subsequent major developments in surgical techniques and medical research. The Board stated: "We have no difficulty concluding that the new evidence, which includes medical studies published in the more than 32 years since issuance of the 1981 report underlying the" surgery exclusion "and demonstrates that transsexual surgery is safe and effective and not experimental." Ex. I. at 8.

41. The research and studies supporting the medical necessity, safety, and effectiveness of surgical care for gender dysphoria is the same type of evidence-based data that the medical community routinely relies upon when treating other medical conditions.

42. The widespread acceptance of the treatments for gender dysphoria, including cross-sex hormones and sex reassignment (gender confirmation) surgery, has resulted in the coverage for these therapies by many insurance providers over the past 15 years. For example, the coverage guidelines for Aetna, Anthem, Blue Cross Blue Shield of North Dakota, Cigna, and

United Healthcare (attached as Exhibits J-N) all provide coverage for gender confirmation surgery as medically necessary treatment for gender dysphoria.

CONCLUSION

43. In summary: There is no legitimate medical basis for SDSEHP's exclusion (ww), which categorically excludes coverage for "[s]ervices or drugs related to gender transformations." Contrary to Defendants' Answer at ¶¶ 9, 22, there is no "existing dispute in the medical field" regarding "whether there is a legitimate medical justification" for such exclusions.

44. I may supplement these opinions in response to information produced by Defendants in discovery or in response to Defendants' expert disclosures.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 18th day of March, 2018

George R. Brown, MD